Group Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

** **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND PENALTIES.

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

** **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Cualquier persona quien con conocimiento y con la intensión de defraudar o engañar a cualquier compañía de seguros, incluye información falsa en una solicitud para seguro o introduce, o instiga en la introducción de una reclamación fraudulenta para obtener pago por una pérdida u otro beneficio, o presenta más de una reclamación por la misma pérdida o daño puede ser culpable de cometer un acto criminal. Al ser convicto, ese persona será multada con una cantidad de $5,000 a $10,000, encarcelamiento por tres (3) años o ambos. Circunstancias agravantes o atenuantes podrían resultar en que el período de tiempo de prisión aumente a cinco (5) años o se reduzca a dos (2) años en concordancia.

** **Arkansas and Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in state prison.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Statement of Claim for Living Benefits

United of Omaha Life Insurance Company
Home Office – Omaha, Nebraska

To Be Completed by Insured

Answer all questions that apply.

The Insured or guardian is responsible for completion of this proof without expense to the Company.
The Company in furnishing this form does so without admitting any liability or waiving any of its rights under the policy on which this claim is made.

Insured's full name	Insured's Marital Status	M / S / Wid.	Div. / Legal Sep.	☐ Male ☐ Female	Date of birth	Cert. or Soc. Sec. Number

Home address (Number and Street)	(City)	(State)	(ZIP Code)	Telephone Number

Employed by	Occupation	Date employed

Name of Group	Group Master Policy Number

Describe injury or sickness

Give the date you were first diagnosed for this injury or sickness

On what date were you first treated by a physician?	Name below all physicians who have treated you since that date.

Name	Address	Dates of treatment From	To

Are you insured under any other policies issued by this company? ☐ Yes ☐ No If "Yes," give policy numbers.

I hereby request any living benefit payable to me under the terms of my group life insurance coverage. I understand that any living benefit is payable only while I am alive and that this benefit may be taxed to me when received. In a community property state, my spouse must consent to the payment of this benefit. The consent of my beneficiary is required. I understand that the benefit paid to my beneficiary will be reduced by the amount of living benefit paid to me. I have read and understand the Disclosure Statement for Accelerated Benefits.

Insured's Signature _____ Date _____

Beneficiary's Signature _____ Date _____

Address _____

(Witnesses) _____ Date _____

List of community property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington State.

Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of United of Omaha Life Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below): _____

Printed Name of Insured Person	Printed Name of Authorized Person	Signature of Authorized Person

Relationship to Insured	Date

Notice

GENERAL — FEDERAL TAX LAWS IMPOSE WITHHOLDING REQUIREMENTS WITH RESPECT TO LIFE INSURANCE POLICIES. IF YOU ELECT TO HAVE FEDERAL INCOME TAX WITHHELD FROM PAYMENT, SOME STATES WILL REQUIRE THAT STATE INCOME TAX ALSO BE WITHHELD.

YOU MUST FURNISH YOUR SOCIAL SECURITY NUMBER WHETHER OR NOT YOU ELECT NO WITHHOLDING.

CAUTION — IF YOU ELECT NOT TO HAVE WITHHOLDING APPLY, OR IF YOU DO NOT HAVE ENOUGH FEDERAL INCOME TAX WITHHELD, YOU MAY BE RESPONSIBLE FOR PAYMENT OF ESTIMATED TAX. YOU MAY INCUR PENALTIES UNDER THE ESTIMATED TAX RULES IF YOUR WITHHOLDING AND ESTIMATED TAX PAYMENTS ARE NOT SUFFICIENT FOR THE TAX YEAR.

Required Disclosure Statement For Accelerated Benefits
United of Omaha Life Insurance Company

Living Benefits Are Not Payable If The Master Policy Ends

(Washington — only) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. You may receive as much as 50% of the face amount of your life insurance benefit. **If you receive a payment of accelerated benefit from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI) and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.**

(Generic — all other states) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. You may receive _____ % of the face amount of your life insurance benefit up to a maximum of $ _____ .

Your Life Insurance Death Benefit Will Be Reduced By The Amount Of Accelerated Benefit That Is Paid. Unlike Conventional Life Insurance Benefits, Accelerated Benefits May Be Taxable. You Or Your Designated Beneficiary Should Consult A Personal Tax Advisor.

Accelerated Death Benefit Application Instruction

To apply for an Accelerated Death Benefit, please follow the steps noted below:

Step 1. Attending physicians' Statement of Condition must be filled out in its entirety.
Step 2. You must contact the beneficiary you have noted and inform him/her of your accelerated death benefit request and the amount you have requested.
Step 3. Your beneficiary must complete the Consenting Beneficiary Form and return it to you in order for you to file the claim.
Step 4. Submit both the Physicians' Statement of Condition along with the Consenting Beneficiary Form and return to:

Mutual of Omaha Insurance Company Claims
Mutual of Omaha Plaza
Omaha, NE 68175

Consent Beneficiary Form

I have read and understood that _____ will receive
Name of Insured

the sum of $ _____ , as an Accelerated Death Benefit. I further understand that as the beneficiary, the remaining life insurance benefit will be reduced by _____ %.

_____
Beneficiary Signature Date

_____
Address

To Be Completed By Master Policyholder or Group Administrator (Please Use Typewriter)

Name of Insured

Date of birth	Cert. or Soc. Sec. Number		Eff. date of certificate
Date of employment	Date last at work	Last occupation	Annual salary

Why did he or she cease work on date given above?

Date insurance terminated		If not terminated, give "paid to" date.
Master Policy Number	Insurance class	Amount of life insurance at time of last day of work

Name of beneficiary shown on your records	Address	Relationship to Insured

We hereby certify that, to the best of our knowledge and belief, the above statements are correct.

Name of Group	Branch or division	
Address of Group	Authorized representative's signature	Date

Attending Physician's Statement of Terminal Condition

The patient is responsible for the completion of this form without expense to the Company.

1. PATIENT'S NAME _____ AGE _____

2. HISTORY
   (a) When did symptoms first appear or accident happen? — (a) Mo. _____ Day _____ , _____
   (b) Has patient ever had same or similar condition? If "Yes," state when and describe. — (b) ☐ Yes ☐ No _____

3. PRESENT CONDITION
   (a) Subjective symptoms — (a) _____
   (b) Objective findings (Includes results of current X-rays, EKGs or any other special tests.) — (b) _____
   (c) Is patient (Check one) . . . . . — (c) ☐ ambulatory? ☐ bed confined? ☐ house confined? ☐ hospital confined?

4. DIAGNOSIS _____

5. TREATMENT
   (a) Date of first visit . . . . . — (a) Mo. _____ Day _____ , _____
   (b) Date of last visit. . . . . — (b) Mo. _____ Day _____ , _____
   (c) Frequency of visits. . . . . — (c) ☐ Weekly ☐ Monthly ☐ Other _____
   (d) When did you last examine the patient? . . . . . — (d) Mo. _____ Day _____ , _____

6. TERMINAL CONDITION
   (a) Current treatment
   (b) Prognosis: Is this injury or sickness terminal (expected to result in death within 24 months and from which there is no reasonable prospect of recovery)? ☐ Yes ☐ No If "No," please give expectations for continued survival, _____ months.
   (c) Has patient been seen/examined by any consultant? If so, please attach any pertinent reports (tissue pathology, radiology, oncology, etc.) and name/address of same.

7. MENTAL CONDITION
   Is the patient competent to endorse checks and direct the use of the proceeds thereof? — ☐ Yes ☐ No

8. REMARKS

Date | Type or Print Physician's Name | Tax I.D. or Social Security Number

Signature (Attending Physician) | Degree | Telephone

Street Address | City or Town | State or Province | ZIP Code